

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *72-6*

## CERTIFICATE OF DEATH

Reg. Dist. No. *270*

## 1. PLACE OF DEATH:

County *Somerset*  
 City or town *Crisfield*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *7 days*  
 Hospital, institution, or street address where death occurred:  
*McCready Memorial Hospital*  
 How long in hospital or institution? *7 days*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State *Maryland* County *Somerset*  
 City or town *Marion*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. *# Rt. 1*  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

*Donald E. Adams*

## 3. (b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced  
*Colored*  
 6. (b) Name of husband or wife  
 6. (c) If alive, give age years  
 7. Birth date of deceased (mo., day, yr.) *February 10, 1946*  
 8. AGE: Years Months Days If less than one day  
*0 0 7* hrs. min.  
 9. Birthplace *Crisfield-Somerset-Maryland*  
 (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name *Mitchell Adams*  
 13. Birthplace *Baltimore, Maryland*

MOTHER 14. Maiden name *Marie Cowger*  
 15. Birthplace *Petersburg, West Virginia*

16. Informant *Mitchell Adams*  
 Address *Marion, Maryland, Rt. 1*

17. Burial, cremation, or removal. Which? *Burial* Date thereof *Feb. 18, 1946*  
 (month) (day) (year)  
 Cemetery or crematory *Rehoboth Baptist Cemetery*  
 Location *Rehoboth, Maryland*

18. Funeral director *H. Harvey Bradshaw*  
 Address *Crisfield, Maryland*

19. *2/28* *46* *John J. McLean*  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Feb 17* 19*46*, at *12:45 A.M.*  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
*Feb 10* 19*46* to *Feb 17* 19*46*  
 and that I last saw him alive on *Feb 16* 19*46*

Immediate cause of death  
*pneumonia*  
 Due to *acute bacterial pneumonia* 3 days  
 DURATION

Due to  
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE *Dr. J. McLean* M. D. or other  
 Address *Marion, Md* Date signed *Feb 18 1946*

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 14 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1372

## CERTIFICATE OF DEATH

 01881 261  
 ★ Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Somerset  
 City or town RURAL, Marion  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life time  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset  
 City or town RURAL, Marion  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war .....

## 3.(a) FULL NAME

Lydia E. Ball

## 3.(b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 3, 1894

8. AGE: Years 51 Months 4 Days 11 If less than one day ..... hrs. .... min.

9. Birthplace Manokin-Somerset, Maryland  
 (Town, county, and state)

10. Usual occupation House hold duties

## 11. Industry or business

12. Name Charles Ball13. Birthplace Somerset County, Maryland14. Maiden name Carrie Bromley15. Birthplace Somerset County, Maryland16. Informant Robert Richardson

Address Westover, Maryland, # Rt. 1

17. Burial Date thereof Feb. 17, 1946  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory .....

Location Fruitland, Maryland

18. Funeral director H. Harvey Bradshaw

Address Crisfield, Maryland

19. Feb 28 46 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1946 at 3:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 18 1946 to Feb 14 1946

and that I last saw her alive on Feb 13 1946

Immediate cause of death Acute Myocardial Infarction

Other conditions none

Due to .....

Due to Ischemic

Other conditions Acute Int. Myocardial Infarction

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. .... Date of .....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE Wm. J. Bradshaw M.D.

Address Wm. J. Bradshaw M.D. Date signed Feb 16 46

RECEIVED

MAR 5 1946

BUREAU V. E.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01882

### 1. PLACE OF DEATH:

County Somerset  
City or town RURAL, Pocomoke City  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death 20 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset  
City or town RURAL, Pocomoke City  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Rt. # 1  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Maggie L. Ballard

### 3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife James Ballard

7. Birth date of deceased (mo., day, yr.) March 11, 1891 6.(c) If alive, give age 56 years

8. AGE: Years 54 Months 10 Days 26 If less than one day hrs. min.

9. Birthplace Pocomoke City-Worcester-Maryland  
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER 12. Name Henry Duncan

13. Birthplace Cape Charles, Virginia

MOTHER 14. Maiden name Drucilla Merrill

15. Birthplace Pocomoke City, Maryland

18. Informant James Ballard

Address Pocomoke City, Md. Rt. # 1

17. Burial Date thereof Feb. 10, 1946  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Unionville Cemetery

Location RURAL, Pocomoke City, Md.

18. Funeral director H. Harvey Bradshaw

Address Pocomoke City, Md.

19. Feb 9 1946 Mrs Clayton Davis  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1946 46 12:05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1946 to Feb 7 1946 and that I last saw her alive on Jan 6 1946

Immediate cause of death

DURATION

Chronic Endocarditis 2 1/2 years

Due to

Other conditions Diabetes

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. S. Anderson MD

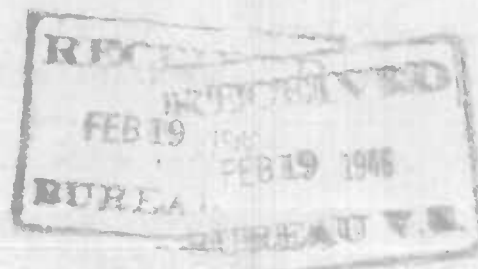
Address Pocomoke City Md M. D. or other

Date signed 2-9-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (134)

## CERTIFICATE OF DEATH

01883

Reg. Dist. No. 270

## 1. PLACE OF DEATH:

County Somerset  
 City or town RURAL, Crisfield  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 28 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Somerset  
 City or town RURAL, Crisfield  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Lawsonia  
 (If rural, give LOCATION)  
 2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Henretta E. Blades

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Henry Blades  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) July 19, 1860  
 8. AGE: Years 85 Months 7 Days 7 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Marion-Somerset-Maryland  
 (Town, county, and state)

10. Usual occupation House wife

## 11. Industry or business

FATHER 12. Name Wm. Henry Matthews  
 13. Birthplace Somerset County, Maryland  
 MOTHER 14. Maiden name Mary Anne Briddell  
 15. Birthplace Somerset County, Maryland

16. Informant Mrs. Ruth B. Tawes

Address Dundalk, Maryland

17. Burial Burial Date thereof Mar. 1, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Pauls Cemetery

Location Marion, Maryland

19. Funeral director Gordon Lawson

Address Crisfield, Maryland

2/27/46 L E Collins M.D.

19. (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1946 at 11:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Feb 26 1946 and that I last saw her alive on Feb 24 1946

Immediate cause of death Acute Dil  
D. Hunt

Due to Chronic D. reg. reg.  
Chronic reg. reg.

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Luise C. Boulton M.D.

Address 274 Marion St.

Date signed \_\_\_\_\_

RECEIVED

MAR 14, 1946

BUREAU V.S.

24-334 21000



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-2)

## CERTIFICATE OF DEATH

Reg. Dist. No. 261

## 1. PLACE OF DEATH:

County Summers  
 City or town Marion Sta.  
 (If outside city or town limits write RURAL and give nearest town)  
 How long in above place of death? 56 Yrs.  
 Hospital, institution, or street address where death occurred:  
R # 1 Home  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Summers  
 City or town Marion  
 (If outside city or town limits write RURAL and give nearest town)  
 Street No. R. # 1  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

John Henry Brinkley  
 4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Wid

## 3. (b) Social Security Number

21216-1601

## 8. (b) Name of husband or wife

Esther Brinkley  
 8. (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Oct. 13 1889

8. AGE: Years 56 Months 3 Days 21 If less than one day  
 hrs. min.

9. Birthplace Marion Sta. Summers  
 (Town, county, and state)

10. Usual occupation Laborer

## 11. Industry or business

12. Name Samuel E. Brinkley

13. Birthplace Marion Sta. Md.

14. Maiden name Nancy A. Whittington

15. Birthplace Marion Sta. Md.

16. Informant Esther Brinkley

Address Maryland

17. Burial Date thereof Feb 10 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Liberia Cemetery

Location Marion Sta. Md.

18. Funeral director Geo. W. Silghausen

Address Marion Sta. Md.

19. 2/67 46 Geo. J. Wilson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 1946 at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 2 1946 to Feb 4 1946 and that I last saw alive on Feb 3 1946

Immediate cause of death Heart  
failure

Due to chronic out. valvula  
coron. insufficiency

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George E. Brinkley M.D. M. D. or other

Address Marion Sta. Md. Date signed Feb 9/46

STATE TO TWENTY-THIRD JUNE 1946

STATE TO TWENTY-THIRD JUNE 1946

RECEIVED  
FEB 11 1946  
BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

## CERTIFICATE OF DEATH

★ 01885360  
Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... Somerset  
 City or town..... Weston  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 71 yrs  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Ind County..... Somerset  
 City or town..... Weston  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Lydia Collins  
 4. Sex..... Fe 5. Color or race..... Colored 6.(a) Single, married, widowed, or divorced..... Widowed

## 3. (b) Social Security Number

## 6. (b) Name of husband or wife

8. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... May 18-1874

8. AGE: Years..... 71 Months..... 8 Days..... 14 If less than one day..... hrs. .... min.

9. Birthplace..... Weston Somerset Ind  
 (Town, county, and state)

10. Usual occupation..... House work

## 11. Industry or business

12. Name..... Noah Gordy  
 13. Birthplace..... Weston Somerset Ind.

14. Maiden name..... Mary Miles  
 15. Birthplace..... Weston Somerset Ind

16. Informant..... David Collins  
 Address..... Weston Ind.

17. Burial..... Burial Date thereof..... Feb 6 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Cottage Grove  
 Location..... Weston Ind

18. Funeral director..... Elias H Ward  
 Address..... Marion St, Ind.

19. Feb. 5, 46 R. H. Johnson, M.D.  
 (Date rec'd by registrar) (Signature of Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb 2nd 1946, at..... 3:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... Jan 27th 1946 to..... Feb 2nd 1946; and that I last saw her alive on..... Feb 2nd 1946

Immediate cause of death.....

Lobar Pneumonia  
 Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

.....Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Eileen G. Mausman  
 M. D. or other.....

Address..... Princeton Ave Ind Date signed..... 2-4-46

RECEIVED  
FEB 6 1946  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(93-2)

## CERTIFICATE OF DEATH

Reg. Dist. No. 1886265

## 1. PLACE OF DEATH:

County Somerset  
 City or town Crisfield  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Lifetime  
 Hospital, institution, or street address where death occurred:  
703 West Main Street  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset  
 City or town \_\_\_\_\_  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 703 West Main Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Frederick L. Godman

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Emily Ruark Godman  
 6.(c) If alive, give age 38 years  
 7. Birth date of deceased (mo., day, yr.) July 28, 1871  
 8. AGE: Years 74 Months 6 Days 22 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Crisfield-Somerset-Maryland  
 (Town, county, and state)  
 10. Usual occupation Coal Dealer  
 11. Industry or business Private business

FATHER 12. Name Thomas Edward Godman  
 13. Birthplace Prince Georges County, Md.

MOTHER 14. Maiden name Isabelle Lankford  
 15. Birthplace Somerset County, Maryland

16. Informant George Warren Godman  
 Address Coles Point, Virginia

17. Burial Burial Date thereof Feb. 22, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Crisfield Cemetery  
 Location Crisfield, Maryland

18. Funeral director Gordon Lawson  
 Address Crisfield, Maryland

19. 2/22/46 19 E. C. Callie, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1946 at 6:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1945 to Feb 19 1946  
 and that I last saw him alive on Feb 28 19 46

Immediate cause of death Chronic myocardial infarction DURATION 1 yr.

Due to myocardial infarction 1 yr.

Due to coronary thrombosis 2 yr.

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE S. M. Peyton M.D.  
 Address Crisfield, Md. Date signed Feb 22 1946

305  
CERTIFICATE OF DEATH

RECEIVED

MAR 14 1916

BUREAU V.B.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

## CERTIFICATE OF DEATH

Reg. Dist. No.

01887

270

## 1. PLACE OF DEATH:

County SomersetCity or town Smith Island  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Elizabeth A. Green

4. Sex Female Color or race White 6. (a) Single, married, widowed, or divorced Married8. (b) Name of husband or wife Charles A.8. (c) If alive, give age 68 years7. Birth date of deceased (mo., day, yr.) November 18 18978. AGE: Years 68 Months 3 Days — If less than one day — hrs. — min. —9. Birthplace Somerset Co. MD  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business None12. Name Franklin Starnison13. Birthplace MD14. Maiden name Mary J. Starnison15. Birthplace MD16. Informant John H. GreenAddress Bisfield MD17. Burial Date thereof 2/20/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Sunny RidgeLocation Bisfield MD18. Funeral director Howard H. HuttarAddress 306 Main St. Bisfield MD19. 2/19/46 Registrar C. E. Holloman  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Cresfield  
(If outside city or town limits, write RURAL and give nearest town)Street No. Maple St  
(If rural, give LOCATION)2. (d) If veteran, name war None

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 18 1946 at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

was dead when I wasand that I last saw him alive onImmediate cause of death Called

DURATION

Coronary OcclusionDue to Arterio SclerosisOther conditions William H. Campbell, M.D.Major findings of operations DEPUTY H. CAMPBELL, M.D.Date of death FOR SO. MIDDLEBURY COUNTY, MD.Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE W. H. CampbellAddress Bisfield MD Date signed 2/19/46

RECEIVED

MAR 14 1946

BUREAU

44-38861-32 241 p/10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 270

## 1. PLACE OF DEATH:

County Somerset  
 City or town Crisfield  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 13 days  
 Hospital, institution, or street address where death occurred:  
McCready Memorial Hospital  
 How long in hospital or institution? 13 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset  
 City or town RURAL, Kingston  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Hudsons  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Annie Holden

## 3. (b) Social Security Number

4. Sex <u>Female</u>	5. Color or race <u>Colored</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>	
6. (b) Name of husband or wife <u>Fuller Holden</u>			
8. (c) If alive, give age <u>38</u> years			
7. Birth date of deceased (mo., day, yr.) <u>December 16, 1905</u>			
8. AGE: Years <u>40</u>	Months <u>1</u>	Days <u>29</u>	If less than one day hrs. min.
9. Birthplace <u>Rehobeth-Somerset-Maryland</u> (Town, county, and state)			
10. Usual occupation <u>Canning Factory Worker</u>			
11. Industry or business <u>Tomato Factory</u>			
FATHER	12. Name <u>William Taylor</u>		
	13. Birthplace <u>Marumsco, Maryland</u>		
MOTHER	14. Maiden name <u>Ella Wilkins</u>		
	15. Birthplace <u>Kingston, Maryland</u>		
16. Informant <u>Fuller Holden</u> Address <u>Kingston, Maryland</u>			
17. Burial Date thereof <u>Feb. 18, 1946</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematorium <u>Marumsco Cemetery</u> Location <u>RURAL, Marion, Maryland</u>			
18. Funeral director <u>H. Harvey Bradshaw</u> Address <u>Crisfield, Maryland</u>			
19. <u>2/20</u> <u>46</u> <u>Anna J. Nelson</u> (Date rec'd by registrar) (month) (day) (year) Registrar			

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1946 at 3:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1946 to Feb 15 1946 and that I last saw her alive on Feb 14 1946

Immediate cause of death Acute Dis. of Heart  
venous Acute infarct

Due to Chronic myocardial  
Chronic infarct

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Supa C. Williams  
 M. D. or other  
 Address Marion St. Md Date signed Feb 17, 46

RECEIVED

MAR 14 1946

BUREAU V.A.

100-5553

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

## CERTIFICATE OF DEATH

01889  
Reg. Diat. No. 260

### 1. PLACE OF DEATH:

County Somerset

City or town Manokin  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 3. (a) FULL NAME

Annie Mary Horsey

### 3. (b) Social Security Number

4. Sex

Female

5. Color or race

col.

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Feb. 3, 1946

6. (c) If alive, give age.....years

8. AGE:

Years

Months

Days

If less than one day

1/2 hrs.

min.

9. Birthplace

Manokin, Somerset Co., Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER  
MOTHER

12. Name  
13. Birthplace  
14. Maiden name  
15. Birthplace

Leon Horsey  
Somerset Co., Maryland  
Emma Cannon  
Georgetown, Delaware

16. Informant

Address

Emma Horsey  
Manokin, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 4 1946  
(month) (day) (year)

Cemetery or crematory

Jamestown Cemetery

Location

Manokin, Maryland

18. Funeral director

Address

father burying child at  
family burying grounds

19. Date rec'd by registrar

Feb. 4 46

R. N. Johnson, M.D.  
for g.d.

Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset

City or town Manokin  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3, 1946 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to.....19.....

and that I last saw h.....alive on.....19.....

Immediate cause of death

Six mo. baby lived purg a few minutes

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. Johnson M.D. - Health Officer

M. D. or other

Address Primer Ave Md

Date signed Feb 4-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 6 1946

BUREAU V S



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19106

## CERTIFICATE OF DEATH

Reg. Dist. No. 01890 261

## 1. PLACE OF DEATH:

County SomersetCity or town Marion  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 64

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County SomersetCity or town Marion  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Elizabeth Horsey

## 3. (b) Social Security Number

218-16-71704. Sex Female5. Color or race Col6.(a) Single, married, widowed, or divorced widowed6.(b) Name of husband or wife Joseph Horsey

B.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Sept 20 - 18818. AGE: Years 64 Months 5 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Camfield Somerset Co Md  
(Town, county, and state)10. Usual occupation House work & seafood work

## 11. Industry or business

12. Name Philip Bullin13. Birthplace Camfield Somerset Co Md14. Maiden name Harritt Ward15. Birthplace Marion Somerset Md16. Informant Effie HorseyAddress Marion Md.17. Burial Date thereof Feb 28 1946  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory BranchLocation Marion Md18. Funeral director Chas H WardAddress Marion Md.19. 78 46 Chas J Wilson  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1946, at \_\_\_\_\_ M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 17 1946, to Feb 24 1946;and that I last saw him alive on Feb 23 1946.Immediate cause of death Heart

## DURATION

Due to Coronary Arteriosclerosis In Feb 1946Due to Chronic Left ventricular failure YesOther conditions Chronic myocarditis

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Philip Bullin M.D. M. D. or other \_\_\_\_\_Address Feb 26 46 Marion Md Date signed \_\_\_\_\_

CERTIFICATE OF DEATH

RECEIVED

MAR 1 1946

BUREAU V. E.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 35

## CERTIFICATE OF DEATH

01891

Reg. Dist. No. 260

### 1. PLACE OF DEATH:

County Somerset  
City or town Manokin  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 24  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD. County Somerset  
City or town Manokin  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Emma Horsey

### 3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife Leon Horsey 46  
7. Birth date of deceased (mo., day, yr.) Sept. 26, 1901 8.(c) If alive, give age 45 years  
8. AGE: Years 44 Months 8 Days 23 If less than one day  
9. Birthplace George Town, Sussex Co., Del.  
(Town, county, and estate)  
10. Usual occupation Housework  
11. Industry or business

FATHER 12. Name Norace Williams Cannon  
13. Birthplace Cannon's Crossing Kent Co. Del.  
MOTHER 14. Maiden name Virgie Anders  
15. Birthplace Unknown

16. Informant Bertha Horsey  
Address Manokin, Md.  
17. Burial Date thereof Feb. 24, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cottage Grove  
Location Westover, Ind.  
18. Funeral director Charles H. Ward.  
Address Marion, Sts., Md.

19. Feb 28, 46 Date rec'd by registrar  
R. D. Johnson Jr. Registrar  
Des. 4-6

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 19 46 at 10 P. M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 2 19 46 to Feb 2 19 46  
and that I last saw him alive on Feb 9 19 46

Immediate cause of death cause unknown  
natural cause DURATION

Due to  
Due to  
Other conditions Exposure  
Influenza  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underlie the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Frank Watson  
D. G. G. G. G. M. D. or other  
Address 2/20/46 Date signed

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

## CERTIFICATE OF DEATH

01892

Reg. Dist. No. 261

1. PLACE OF DEATH:  
 County..... Somerset  
 City or town..... Marion  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 6 yrs  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Ind County..... Somerset  
 City or town..... Marion  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME  
Van Jones

3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... Colored 6.(a) Single, married, widowed, or divorced..... widowed

6.(b) Name of husband or wife..... on known

7. Birth date of deceased (mo., day, yr.)..... 1874 6.(c) If alive, give age..... years

8. AGE: Years..... 72 Months..... Days..... If less than one day..... hrs. .... min.

9. Birthplace..... on known  
 (Town, county, and state)

10. Usual occupation..... laborer

11. Industry or business.....

FATHER 12. Name..... on known

13. Birthplace.....

MOTHER 14. Maiden name..... on known

15. Birthplace.....

16. Informant..... Clay Byrd

Address..... Marion Ind

17. (Burial, cremation, or removal. Which?)..... burial Date thereof..... Mar 2 1946  
 (month) (day) (year)

Cemetery or crematory..... branch

Location..... Marion Ind

18. Funeral director..... Chas H Ward

Address..... Marion Ind

19. 3/2/46 19..... James Marion  
 (Date rec'd by registrar) Registrar

During MEDICAL CERTIFICATION  
 20. DATE OF DEATH..... Night of Feb 27 1946 at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
was born when I 19.....  
 and that I last saw him was called 19.....

Immediate cause of death..... Coronary Sclerosis

Due to..... Arterio Sclerosis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.....

Autopsy results..... no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... James Marion  
County Medicine Examiner for  
Ind of other

Address..... Marion Ind Date signed..... 3/2/46

RECEIVED  
MAR 4 1946  
BUREAU V. R.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01893

Reg. Dist. No. 260

## 1. PLACE OF DEATH:

County SomersetCity or town Princess Anne, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Mt Vernon, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Lester O. Jones

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

M

W

Married

6. (b) Name of husband or wife Eva Jones7. Birth date of deceased (mo., day, yr.) August 23, 18798. AGE: Years Months Days If less than one day  
66 6 14 hrs. min.9. Birthplace Mt Vernon, Md.  
(Town, county, and state)10. Usual occupation Carpenter11. Industry or business Filling Station Operator12. Name Robert Jones13. Birthplace Mt Vernon, Md.14. Maiden name Caroline Morris15. Birthplace Mt Vernon, Md.16. Informant Eva JonesAddress Princess Anne, Md.17. Burial Date thereof Feb. 8, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory John Wesley CemeteryLocation Mt Vernon, Md.18. Funeral director Dale DashiellAddress Princess Anne, Md.19. Feb 8 46 P. J. Johnson, M.D.  
(Date rec'd by registrar) (year) (month) (day) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6th 1946, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19 19Immediate cause of death Tuberculosis

DURATION

10 mos

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Princess Anne, Md. Date signed 2/7-46

RM  
FEB 9 1945  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

## CERTIFICATE OF DEATH

01894

Reg. Dist. No. 360

## 1. PLACE OF DEATH:

County Somerset  
 City or town Marion in and  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex Female 5. Color or race Col 6. (a) Single, married, widowed, or divorced Married

8. (b) Name of husband Dr. King

7. Birth date of deceased (mo., day, yr.) Jan 1 - 1871 8. (c) If alive, give age 75 years

8. AGE: Years 75 Months 0 Days 0 It less than one day hrs. min.

9. Birthplace Ind (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business None

12. Name Mr. Anderson

13. Birthplace Ind

14. Maiden name Miss Anderson

15. Birthplace Ind

16. Informant Dr. King

Address Marion in and

17. (Burial, cremation, or removal. Which?) Burial Date thereof March 3rd 46 (month) (day) (year)

Cemetery or crematory East P. Cemetery

Location East P. Cemetery

18. Funeral director Chas. Ward

Address Marion in and

19. March 1, 46 R. H. Johnson, M.D. Registrar

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset

City or town Marion in  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.   
 (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28th 1946 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death Myocardial DURATION

Due to Myocardial

Due to Myocardial

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations  Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of

Where did injury occur?  (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury  Injured at work?

Signature R. H. Johnson M. D. or other

Address Marion in and Date signed 3/1/46

RECEIVED  
MAR 4 1946  
BUREAU V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(107)

01895

## CERTIFICATE OF DEATH

Reg. Dist. No. 261

1. PLACE OF DEATH: Somerset  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 MO  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Md County..... Somerset  
City or town..... Marion  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME  
Margo Pauline Miles

3. (b) Social Security Number

4. Sex..... Female 5. Color & race..... Colored 6. (a) Single, married, widowed, or divorced..... infant

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) OCT 2 - 1945

8. AGE: Years..... 4 Months..... 5 Days..... less than one day..... hrs. .... min.

9. Birthplace..... Marion Somerset Co Md  
(Town, county, and state)

10. Usual occupation..... inf

11. Industry or business.....

12. Name..... Charles Miles

13. Birthplace..... Marion Somerset Co Md

14. Maiden name..... Chris Archie

15. Birthplace..... Accomac Va

16. Informant..... Charles Miles

Address..... Marion Md

17. Burial, cremation, or removal. Which? burial Date thereof Feb 8, 1946  
(month) (day) (year)

Cemetery or crematory..... Wesley cemetery

Location..... Marion Md

18. Funeral director..... Chas H Wood

Address..... Marion Md

19. 2/8 46 2/8 46 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 7, 1946 at 4 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased prior to death and that I last saw him..... came to me

Immediate cause of death.....

sleeping between parents & died during night

was dead when mother awoke & parent cause smothered -

Other conditions..... not severe cold possible Ruptured Membrane

Major findings of operations.....

DEPUTY MEDICAL EXAMINER

FOR SOMERSET COUNTY, MD.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

Signature..... W. H. Coulbourn, M. D.

Address..... Crisfield Md

Date signed..... 2/7/46

STATION 10 THE TITANIC ZONE CHARTER

RECEIVED

RECEIVED

FEB 11 1946

BUREAU V. E.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 261

## 1. PLACE OF DEATH:

County SummitCity or town Monkton  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? all life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County SummitCity or town Monkton Po Summit Co md  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)2(a) If veteran, name war md

## 3. (a) FULL NAME

Robert Ronald Moody

## 3. (b) Social Security Number

4. Sex Male5. Color or race Col.6. (a) Single, married, widowed, or divorced Single6. (b) Name of husband or wife mr7. Birth date of deceased (mo., day, yr.) Sept. 14, 1945  
8. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 6 Months 7 Days 15 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Monkton  
(Town, county, and state)10. Usual occupation Infant

## 11. Industry or business

12. Name Ernest Moody13. Birthplace md.14. Maiden name Emelyn Johnson15. Birthplace md.16. Informant Ernest MoodyAddress Monkton Summit Co md17. Burial Date thereof Feb 23, 46  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematorium Samuel Wesley CemeteryLocation Monkton Summit Co md18. Funeral director FatherAddress Monkton Po Summit Co md19. Feb 25 46 Chas J Wilson  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1946, at 6:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1946 to Feb 22 1946and that I last saw him alive on Feb 18 1946Immediate cause of death Acute DehydrationDUE TO Hypertension

DUE TO \_\_\_\_\_

DUE TO \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE George C. Pullman

M. D. or other \_\_\_\_\_

Address Monkton Po Summit Co md Date signed Feb 23, 46

RECEIVED  
FEB 28 1946  
BUREAU V A

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B2)

## CERTIFICATE OF DEATH

Reg. Dist. No. 01897 270

### 1. PLACE OF DEATH

County Carroll  
City or town Summit  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

How long in hospital or institution?

How long in hospital or institution? McClary Mem. Hosp.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Summit  
City or town Manokin  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

William Francis O'Malley

### 3. (b) Social Security Number

#### 4. Sex

Male

#### 5. Color or race

White

#### 6. (a) Single, married, widowed, or divorced

Married

#### 6. (b) Name of husband or wife

Ruth Clark O'Malley

#### 7. Birth date of deceased (mo., day, yr.)

May 22<sup>nd</sup> 1887

#### 8. AGE:

58 Years

8 Months

20 Days

If less than one day

hrs.

min.

#### 9. Birthplace

Genova, N.Y.

(Town, county, and state)

#### 10. Usual occupation

Medical Doctor

#### 11. Industry or business

Michael O'Malley

#### 12. Name

#### 13. Birthplace

#### 14. Maiden name

#### 15. Birthplace

#### 16. Informant

#### 17. Burial

#### 18. Funeral director

#### 19. Address

#### 20. Date of death

#### 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

#### 22. VIOLENCE: If death was due to external causes, fill in the following:

#### 23. SIGNATURE

#### 24. Address

#### 25. Date signed

#### 26. Registrar

#### 27. Date rec'd by registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1946 at 7:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 5 1946 to Feb 12 1946

and that I last saw him alive on Feb 12 1946

Immediate cause of death Acute Deep Vent

urinary

Due to Chronic Quaternary

urinary

Due to Chronic Quaternary

urinary

Other condition? None

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. \_\_\_\_\_

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Dr. C. C. O'Malley

M. D. or other \_\_\_\_\_

Address Manokin Md

Date signed Feb 12 46

Registrar \_\_\_\_\_

Date rec'd by registrar \_\_\_\_\_

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 20 1946

BUREAU

RECEIVED

FEB 20 1946

BUREAU V.M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1312)

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Somerset  
 City or town Crisfield  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 68 years  
 Hospital, institution, or street address where death occurred:  
102 Cove Street  
 How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset  
 City or town Crisfield  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 102 Cove Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war .....

## 3.(a) FULL NAME

Rachel Annie Sterling

## 3.(b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Severn Sterling  
 6.(c) If alive, give age ..... years  
 7. Birth date of deceased (mo., day, yr.) January 2, 1861  
 8. AGE: Years 85 Months 1 Days 15 If less than one day ..... hrs. .... min.

9. Birthplace Newark-Worcester-Maryland  
 (Town, county, and state)

10. Usual occupation House wife

11. Industry or business .....

FATHER 12. Name Sidney Trader

13. Birthplace .....

MOTHER 14. Maiden name Mary Jane Bradford

15. Birthplace .....

16. Informant Edward Sterling

Address 102 Cove Street, Crisfield, Md.

17. Burial Burial Date thereof Feb. 20, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Crisfield Cemetery

Location Crisfield, Maryland

18. Funeral director H. Harvey Bradshaw

Address Crisfield, Maryland

19. 4/1/46 B E Callender  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17, 1946 at 11:44 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 17, 1946 to Feb. 17, 1946

and that I last saw him alive on Feb. 17, 1946

Immediate cause of death Cerebral hemorrhage

Artero-vascular

Rural clinic

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Chas. P. Schwetke M. D. or other

Crisfield Date signed 2/8/46

245

949.0

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MAR 14 1946  
BUREAU V.S.

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

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## CERTIFICATE OF DEATH

Reg. Dist. No. 268

## 1. PLACE OF DEATH:

County SomersetCity or town Chauce, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Chauce  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Thomas H. Laukersley

## 3. (b) Social Security Number

none

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

8. (b) Name of husband or wife

Lottie Laukersley

8. (c) If alive, give age. \_\_\_\_\_ years

7. Birth date of

deceased (mo., day, yr.)

Feb. 13, 1865

8. AGE:

Years

Months

Days

If less than one day

819

hrs.

min.

9. Birthplace

West Island, Md.

(Town, county, and state)

10. Usual occupation

Waterman

11. Industry or business

FATHER

12. Name

Valentine Laukersley

13. Birthplace

West Island, Md.

MOTHER

14. Maiden name

Cooper Webster

15. Birthplace

West Island, Md.

16. Informant

Mrs. Elizabeth Young

Address

Princess Anne, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 24, 1946  
(month) (day) (year)

Cemetery or crematory

Chauce Cemetery

Location

Chauce, Maryland

18. Funeral director

Dale Dashiell

Address

Princess Anne, Md.

19.

(Date read by registrar)

Feb. 23, 1946Rosa Webster

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22 1946, at 12:25 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19\_\_\_\_, to 19\_\_\_\_

and that I last saw him alive on 19\_\_\_\_

Immediate cause of death

Myocardial

DURATION

Due to

Due to

Other conditions

Arterio Sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. Smith

M. D. or other

Address

Princess Anne, Md.

Date signed

2/23-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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FEB 26 1946

BUREAU V S

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

## CERTIFICATE OF DEATH

Reg. Dist. No. 01990 268

### 1. PLACE OF DEATH:

County Worcester  
City or town Worcester  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Worcester  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

David White

### 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Mary White

7. Birth date of deceased (mo., day, yr.)

Not Obtainable

8. AGE:

68

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Worcester  
(Town, county, and state)

10. Usual Occupation

Wolfsman

11. Industry or business

Cash Fish, Oysters, etc

FATHER

12. Name

Wm E White

13. Birthplace

Worcester, Md

MOTHER

14. Maiden name

Anne Curtis

15. Birthplace

Worcester, Md

16. Informant

John Parkinson

Address

Worcester, Md

17. (Burial, cremation, or removal. Which?)

Date thereof July 17, 1946

Cemetery or crematory

St Paul's M E

Location

Worcester, Md

18. Funeral director

Isperbsen

Address

Deal Island, Md

19. Feb 16 19 46

Rosa Webster

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 19 46 at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 11 19 45 to Jan 20 19 46

and that I last saw him alive on Jan 20 19 46

Immediate cause of death

Carcinoma of Stomach

DURATION

1 yr

Due to

Due to

Other conditions

(Include pregnancy within 5 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank Matas MD

M. D. or other

Address

Princess Anne

Date signed Feb 16

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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FEB 26 1946

BUREAU V.S.